DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
(OMB NO. 0938-0193)

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICAID AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: TN 04-0001

2. STATE: Ohio

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Title XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 8, 2004

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN x AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1902 (a)(13)(A) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 ($ 0)
b. FFY 2005 ($ 0)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19D rules: 5101:3-3-40
5101:3-3-77
5101:3-3-85.1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19D rules: 5101:3-3-40
5101:3-3-77
5101:3-3-85.1

10. SUBJECT OF AMENDMENT:
The rules contained in this amendment were reviewed pursuant to Section 119.032 of the Ohio Revised Code. The purpose of the review was to determine whether a rule should be continued without amendment, be amended, or be rescinded, taking into consideration the rule's purpose and scope.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
x OTHER, AS SPECIFIED:
The Governor's office has delegated review to the Director of ODJFS.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Thomas J. Hayes

14. TITLE:
Director

15. DATE SUBMITTED:
March 15, 2004

16. RETURN TO:
Becky Jackson
Bureau of Health Plan Policy
Ohio Department of Job and Family Services
30 East Broad Street, 27th floor
Columbus, Ohio 43215-3414

FOR REGIONAL OFFICE USE ONLY

5101:3-3-40 **Nursing facility (NF) case mix assessment instrument: minimum data set version 2.0 (MDS 2.0).**

(A) As used in this rule:

(1) "Annual facility average case mix score" is the score used to calculate the facility's cost per case mix unit, and is calculated using the methodology described in paragraph (E) of rule 5101:3-3-42 of the Administrative Code.

(2) "Case mix report" is a report generated by the Ohio department of job and family services (ODJFS) and distributed to the NF on the status of all MDS 2.0 assessment data that pertains to the calculation of a quarterly or an annual average facility case mix score.

(3) "Comprehensive assessment" means an assessment that includes completion of not only the MDS 2.0 designated for use in Ohio but also completion of the resident assessment triggers, the resident assessment protocols (RAPs), and the resident assessment protocols summary ~~"RAP Summary"~~ form.

(4) "Critical elements" are data items from a resident's minimum data set version 2.0 (MDS 2.0) that ODJFS verifies prior to determining a resident's resource utilization group, version III (RUG III) class.

(5) "Critical errors" are errors in the MDS 2.0 critical elements that prevent ODJFS from determining the resident's RUG III classification.

(6) "Cost per case mix unit" is calculated by dividing the facility's desk-reviewed, actual, allowable per diem direct care costs for the calendar year preceding the fiscal year in which the rate will be paid by the annual facility average case mix score for the calendar year preceding the fiscal year in which the rate will be paid. The lesser of the facility's cost per case mix unit or the maximum allowable cost per case mix unit for the facility's peer group for the fiscal year shall be used to determine the facility's rate for direct care costs, in accordance with rule 5101:3-3-44 of the Administrative Code.

(7) "Default group" is RUG III group forty-five, the case mix group assigned to residents for whom missing or inaccurate data precludes classification into RUG III groups one through forty-four.

(8) "Direct care peer group" is a group of Ohio medicaid-certified NFs determined by ODJFS to have significant per diem direct care cost differences from the other direct care peer groups due to reasons other than the differences in care needs among the residents. Direct care peer groups are described in rule

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5101:3-3-44 of the Administrative Code.

(9) "Encoded," when used with reference to a record, means that the record has been recorded in electronic format. The record must be encoded in accordance with the United States ~~health care financing administration (HCFA)~~centers for medicare and medicaid services (CMS) uniform data submission document and state specifications.

(10) "Filing date" is the deadline for submission of the NF's MDS 2.0 assessment data that will be used for rate setting purposes. The filing date is the fifteenth calendar day following the reporting period end date.

(11) "Locked" means a record has been accepted into the state database.

(12) "MDS 2.0 correction request form" (CRF) is the mechanism used to request correction of error(s), to identify the inaccurate record and to attest to the correction request. A correction request can be made to either modify or inactivate an MDS 2.0 assessment record or an MDS 2.0 discharge or reentry tracking form that has been previously accepted into the state MDS 2.0 database.

(13) "MDS 2.0" is the core set of screening and assessment elements designated by Ohio and approved by ~~HCFA~~CMS that forms the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in medicaid and medicare. The MDS 2.0 provides the resident assessment data which is used to classify the resident into a resource utilization group (RUG) in the RUG III case mix classification system.

(14) "Medicare required assessment" means the MDS 2.0 specified for use in Ohio that is required only for facilities participating in the medicare prospective payment system but does not include the triggers, RAPs, and RAP summary form.

(15) "Payment quarter" is ~~the~~two ~~quarter~~quarters following the ~~processing~~reporting quarter and is the quarter following the processing quarter, in which the direct care rate is paid based on the quarterly facility average case mix score from the reporting quarter's MDS 2.0 data.

(16) "Processing quarter" is the quarter that follows the reporting quarter and is the quarter in which ODJFS calculates the quarterly facility average case mix score.

(17) "Quarterly facility average case mix score" is the facility average case mix score based on data submitted for one reporting quarter and is calculated using the methodology described in rule 5101:3-3-42 of the Administrative Code.

(18) "Quarterly review assessment" means an assessment that is normally conducted no less than once every three months using the MDS 2.0 designated for use in Ohio that does not include the triggers, RAPs, and RAP summary form.

(19) "Record" means a resident's encoded MDS 2.0 assessment as described in paragraphs (B)(1) to (B)(3) of this rule.

(20) "Relative resource weight" is the measure of the relative costliness of caring for residents in one case mix group versus another, indicating the relative amount and cost of staff time required on average for defined worker classifications to care for residents in a single case mix group. The methodology for calculating relative resource weights is described in rule 5101:3-3-41 of the Administrative Code.

(21) "Reporting period end date" (RPED) is the last day of ~~the~~each calendar quarter.

(22) "Reporting quarter" is the calendar quarter in which the MDS 2.0 is ~~conducted~~completed, as indicated by the assessment reference date in MDS 2.0 section A, item 3a, except as specified in paragraphs (C)(7) and (C)(9) of this rule.

(23) "Resident Assessment Instrument (RAI)" is the instrument used by NFs in Ohio to comply with 42 code of federal regulations (CFR) section 483.20 (10-1-02 edition http://www.access.gpo.gov/nara/cfr/index.html) and provides a comprehensive, accurate, standardized, reproducible assessment of each long term care facility resident's functional capabilities and identifies medical problems. The Ohio-specified and federally-approved instrument is composed of the MDS 2.0, triggers, ~~resident assessment protocols~~ (RAPs) and the RAP summary form.

(24) "Resident assessment protocols (RAPs)" are structured, problem-oriented frameworks for organizing MDS information, and forms the basis for individualized care planning.

(25) The "resident assessment protocol ~~(RAP)~~ summary" form is used to document

which RAPs were triggered, whether or not care planning will be done for the triggered condition and where summary data from the RAP review process is documented. It is part of the RAI and must be completed for all comprehensive assessments.

(26) "Resident case mix score" is the relative resource weight for the RUG III group to which the resident is assigned based on data elements from the resident's MDS 2.0 assessment.

(27) "RUG III" is the resource utilization groups, version III system of classifying NF residents into case mix groups described in rule 5101:3-3-41 of the Administrative Code. Resource utilization groups are clusters of NF residents, defined by resident characteristics, that ~~explain~~correlate with resource use.

(28) "Triggers" are specific resident responses for one or a combination of MDS 2.0 elements. These triggers identify residents who require further evaluation using resident assessment protocols designated within the state specified RAI.

(B) For the purpose of determining medicaid payment rates for NFs effective October 1, 2000 and thereafter, ODJFS shall accept the RAI specified by the state and approved by ~~HCFA~~CMS. Each NF shall assess all residents of medicaid-certified beds~~,~~ as defined in ~~paragraph (C) of~~ this rule, using the MDS2.0 as set forth in Appendix A of this rule.

(1) Comprehensive assessments, medicare-required assessments, quarterly review assessments and significant corrections of quarterly assessments must be conducted in accordance with the requirements and frequency schedule found at 42 CFR section 483.20 (10-1-02 edition http://www.access.gpo.gov/nara/cfr/index.html).

(a) Comprehensive assessments, including the MDS 2.0, triggers, RAPs and RAPs summary, are required for all initial assessments, significant change assessments, annual assessments and significant correction of previous comprehensive assessments.

(b) The MDS~~:~~ 2.0 is required for all medicare-required assessments, quarterly assessments, significant corrections of previous quarterly assessments, and significant corrections of previous medicare required assessments.

(2) NFs must use the Ohio-specified MDS 2.0, as set forth in appendix A, including sections S, and T~~, and U~~, for all comprehensive assessments,

~~medicare-required assessments,~~ quarterly review assessments, significant change assessments, and significant correction assessments.

(3) NFs must use the MDS 2.0 discharge tracking form as set forth in appendix B of this rule for any residents who transfer, are discharged or expire, and the MDS 2.0 reentry tracking form as set forth in appendix C of this rule for any residents reentering the facility in accordance with 42 CFR section 483.20 (10-1-02 edition http://www.access.gpo.gov/nara/cfr/index.html).

(4) NFs must use the MDS correction request form as set forth in appendix D of this rule for modification or inactivation of MDS records that have been accepted into the state MDS database.

(5) NFs may use the MDS medicare PPS (prospective payment system) assessment form (MPAF) for all medicare-required assessments as set forth in appendix E of this rule. When the assessment reference date (ARD) is subsequent to the reporting period end date, the date of entry (MDS 2.0 item AB1) must also be submitted for medicaid rate setting purposes as delineated in the "CMS Revised Long-Term Care Resident Assessment Instrument User's Manual version 2.0" (December 2002 http://cms.hhs.gov/medicaid/mds20/man-form.asp).

(C) Effective July 1, 1998, all NFs must submit to the state encoded, accurate, and complete MDS 2.0 data for all residents of medicaid-certified NF beds, regardless of pay source or anticipated length of stay.

(1) MDS 2.0 data completed in accordance with paragraphs (B)(1) to (B)(3) of this rule must be encoded in accordance with 42 CFR section 483.20 (10-1-02 edition http://www.access.gpo.gov/nara/cfr/index.html), ~~HCFA's~~CMS' uniform data submission document, and state record layout specifications.

(2) MDS 2.0 data must be submitted in an electronic format via modem and in accordance with the frequency schedule found in 42 CFR section 483.20 (10-1-02 edition http://www.access.gpo.gov/nara/cfr/index.html). The data may be submitted at any time during the reporting quarter that is permitted by instructions issued by the state, but, except as provided in paragraphs (D) and (E) of this rule, all records used in quarterly rate-setting must be submitted by the filing date.

(3) If a NF submits MDS 2.0 data needed for quarterly rate-setting after the filing date, ODJFS may assign, for a period of not more than one month per quarter, a quarterly facility average case mix score as set forth in paragraph ~~(E)~~(D)(3) of rule 5101:3-3-42 of the Administrative Code.

(4) Data submitted electronically by a NF does not meet the requirements for timely and accurate submission if it cannot be processed by ODJFS (for example, rejection of the entire data file, submission of a blank file, etc.) and may result in assignment of a quarterly average case mix score as set forth in rule 5101:3-3-42 of the Administrative Code.

(5) The annual and quarterly facility average case mix scores will be calculated using the MDS 2.0 record in effect on the reporting period end date for:

(a) Residents who were admitted to the medicaid certified NF prior to the reporting period end date and continue to be physically present in the NF on the reporting period end date; and

(b) Residents who were admitted to the NF on the reporting period end date from a non-NF setting (home, hospital, adult care facility, residential care facility, intermediate care facility for the mentally retarded (ICF-MR); and

(c) Residents who were transferred into the NF from another NF on the reporting period end date; and

(d) Residents who were temporarily absent on the reporting period end date but are considered residents and for whom a ~~bed is being held for their~~ return is anticipated from hospital stays, visits with friends or relatives, or participation in therapeutic programs outside the facility.

(6) Records for residents who were permanently discharged from the NF, transferred to another NF, or expired prior to or on the reporting period end date will not be used for rate setting.

(7) For a resident admitted within fourteen days of the reporting period end date, and whose initial assessment is not due until after the reporting period end date, both of the following shall apply:

(a) The NF shall submit the appropriate initial assessment as specified in the MDS 2.0 manual (December 2002 http://cms.hhs.gov/medicaid/mds20/man-form.asp) and in 42 CFR 483.20 (10-1-02 edition http://www.access.gpo.gov/nara/cfr/index.html); and

(b) The initial assessment, if completed and submitted timely in accordance

with paragraph (C)(7)(a) of this rule, shall be used for rate setting in the quarter the resident entered the facility even if the assessment reference date is after the reporting period end date.

(8) For a resident discharged prior to the completion of an initial assessment, all of the following shall apply:

(a) The NF shall submit a Discharge Tracking Form with the reason for assessment (MDS 2.0, item AA8a) coded as "eight", discharged prior to completing initial assessment".

(b) The discharge status (MDS 2.0 item R3) shall be coded "one" through "nine" as appropriate.

(c) The resident specific case mix score for clinically complex category, group twenty two, class "CC1" shall be assigned for a resident of the facility on the RPED who was either:

(i) Admitted in the final fourteen days of the calendar quarter and whose initial assessment was not completed because the resident was discharged or expired.

(ii) Admitted in the final thirty days of the calendar quarter and was admitted to the hospital prior to the completion of the initial assessment, and is still in the hospital on the RPED.

(9) For a resident who had at least one MDS 2.0 assessment completed before being transferred to a hospital, reenters the NF within fourteen days of the reporting period end date, and has experienced a significant change in status that requires a comprehensive assessment upon reentry,

(a) The NF shall submit a significant change assessment within fourteen days of reentry, as indicated by the MDS 2.0 assessment reference date (MDS 2.0, item A3).

(b) The significant change assessment shall be used for rate setting for the quarter in which the resident reentered the facility even if the assessment reference date is after the reporting period end date.

(D) Corrections to MDS 2.0 data must be made in accordance with the requirements in the "CMS Revised Long Term Care ~~Facility (LTCF) RAI~~ Resident Assessment Instrument User's Manual" version 2.0", ~~the "Long Term Care RAI version 2.0~~

~~provider instructions for making automated corrections using the new MDS2.0 CRF"~~ and the "State ~~Operation~~Operations Manual" (SOM) issued by ~~HCFA~~CMS (http://cms.hhs.gov/manuals/pub07pdf/pub07pdf.asp).

(1) Corrections to MDS 2.0 data can be made as follows:

(a) Prior to transmission to the state and within seven days after completion of the MDS 2.0, by following the instructions as specified in the "CMS Revised Long Term Care Resident Assessment Instrument ~~LTCF RAI~~ User's Manual" version 2.0", ~~the "Long Term Care RAI version 2.0 provider instructions for making automated corrections using the new MDS CRF"~~ and the SOM issued by ~~HCFA~~CMS (http://cms.hhs.gov/manuals/pub07pdf/pub07pdf.asp).

(b) For rate-setting purposes, the facility has eighty days after the reporting period end date to transmit the appropriate corrections to the state.

(c) After the record is locked, data corrections as specified in the "CMS Revised Long Term Care Resident Assessment Instrument User's Manual version 2.0" (December 2002 http://cms.hhs.gov/medicaid/mds20/man-form.asp),~~Long Term Care RAI version 2.0 provider instructions for making automated corrections using the new MDS CRF"~~ and the SOM issued by ~~HCFA~~CMS (http://cms.hhs.gov/manuals/pub07pdf/pub07pdf.asp).

(d) After the record is locked, correction to the clinical data in the event of a major error can only be made by completing a significant correction assessment or, if there has actually been a significant change in status, a comprehensive significant change assessment. These assessments must be completed in accordance with the instructions in the "CMS Revised Long Term Care Resident Assessment Instrument ~~LTCF RAI~~ User's Manual" version 2.0", ~~the "Long Term Care RAI version 2.0 provider instructions for making automated corrections using the new MDS CRF"~~ and the SOM as issued by ~~HCFA~~CMS (http://cms.hhs.gov/manuals/pub07pdf/pub07pdf.asp), and require a new observation period and assessment reference date.

(i) For rate-setting purposes, significant correction assessments must have an assessment reference date within the reporting quarter.

(ii) For rate-setting purposes, significant change assessments must have an assessment reference date within the reporting quarter except when used to report a significant change in a resident's status

upon return from a hospital as specified in paragraph (C)(9) of this rule.

(2) It is the provider's responsibility to submit an accurate, encoded MDS 2.0 record for each resident in a medicaid-certified bed on the last day of the calendar quarter.

(a) The facility shall transmit MDS 2.0 assessments that were completed timely but inadvertently omitted from the previous transmissions, and ODJFS shall use the actual case mix scores from these assessments for rate setting purposes, if the assessments are transmitted within eighty days after the reporting period end date. If the assessments are not transmitted within eighty days after the reporting period end date, ODJFS may assign default scores for those records as described in rule 5101:3-3-41 of this Administrative Code.

(b) The facility has eighty days after the reporting period end date to transmit the appropriate discharge tracking form to the state, if the facility identified more residents as being in the facility on the reporting period end date (RPED) than the number of its medicaid-certified beds. If the facility does not correct the error within eighty days after the reporting period end date, ODJFS may assign a facility average case mix score as specified in rule 5101:3-3-42 of the Administrative Code.

(c) The facility shall notify ODJFS within eighty days of the reporting period end date of any records for residents in medicaid-certified beds on the reporting period end date that were not completed timely, and were not transmitted to the state. ODJFS may assign default scores to those records as described in rule 5101:3-3-41 of the Administrative Code.

(d) The facility shall notify ODJFS within eighty days of the reporting period end date of any residents who were reported to be residents of the facility on the reporting period end date, but who had actually been discharged prior to the reporting period end date. If the facility does not correct the error within eighty days after the reporting period end date, ODJFS may assign a facility average case mix score as specified in rule 5101:3-3-42 of the Administrative Code.

(3) If the number of records assigned to the default group in accordance with paragraphs (D)(2)(a) and (D)(2)(c) of this rule is greater than ten per cent, ODJFS may assign a quarterly facility average case mix score, as set forth in paragraph (E) of rule 5101:3-3-42 of the Administrative Code.